



INDIANA HEALTH COVERAGE PROGRAMS

PROVIDER REFERENCE MODULE

Outpatient Facility Services

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Revision History

| Version | Date | Reason for Revisions | Completed By |
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| 1.0 | Policies and procedures as of October 1, 2015 Published: February 25, 2016 | New document | FSSA and HPE |
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| 4.0 | Policies and procedures as of August 1, 2019 Published: October 15, 2019 | Scheduled update: <ul style="list-style-type: none"> • Edited text as needed for clarity • Updated links to the new IHCP website • Modified the initial note box with standard wording • Added a footnote in the Introduction section indicating which clinics bill as outpatient facilities • Added references to the Outpatient Fee Schedule and ASC Code/Rate table in the Reimbursement for Outpatient Facility Services section • Extended the date for the 3% reimbursement reduction for inpatient and outpatient hospital services in the Rate Reduction section • Added a code table reference and billing instructions in the Outpatient Surgeries section for implantable DME that is separately reimbursable | FSSA and DXC |

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| | | <ul style="list-style-type: none"> • In the Treatment Room Visits section, clarified policy and billing guidelines, added a cross-reference for special procedure code linkages for revenue code 724, and included a note with special guidance for revenue code 451 • Added unit restriction information in the Add-On Services section • Clarified that the unit restriction in the Stand-Alone Services section is “per provider” • In the Stand-Alone Chemotherapy and Radiation Services section, added additional reimbursement information regarding the chemotherapy agent and IV equipment | |

Table of Contents

| | |
|---|---|
| Introduction | 1 |
| Reimbursement for Outpatient Facility Services | 2 |
| Rate Reduction..... | 2 |
| Coverage and Billing for Outpatient Facility Services..... | 2 |
| Outpatient Service within 3 Days before an Inpatient Stay | 3 |
| Inpatient Stays Less than 24 Hours | 3 |
| Observation Billing | 3 |
| Outpatient Surgeries..... | 4 |
| Treatment Room Visits | 4 |
| Add-On Services | 5 |
| Stand-Alone Services | 6 |
| Stand-Alone Chemotherapy and Radiation Services | 6 |

Outpatient Facility Services

*Note: The information in this module applies to Indiana Health Coverage Programs (IHCP) services provided under the **fee-for-service (FFS)** delivery system. For information about services provided through the **managed care** delivery system – including Healthy Indiana Plan (HIP), Hoosier Care Connect, or Hoosier Healthwise services – providers must contact the member’s managed care entity (MCE) or refer to the MCE provider manual. MCE contact information is included in the [IHCP Quick Reference Guide](#) available at in.gov/medicaid/providers.*

For updates to information in this module, see [IHCP Banner Pages and Bulletins](#) at in.gov/medicaid/providers.

Introduction

Outpatient facility services are services provided by an acute care hospital, a psychiatric hospital, an ambulatory surgical center (ASC), a clinic¹, or other treatment room setting to individuals who are registered as patients with the facility but not admitted as inpatients.

*Note: If providers not employed by the facility take a tissue sample, blood sample, or specimen and send it to the facility for tests, the service is classified as a **nonpatient** (rather than an **outpatient**) facility service, because the patient did not directly receive the service from the facility.*

The Indiana Health Coverage Programs (IHCP) covers outpatient facility services when such services are provided or prescribed by a physician, and when the services are medically necessary for the diagnosis or treatment of the member’s condition. The member’s medical condition, as described and documented in the medical record by the primary or attending physician, must justify the intensity of service provided.

This module contains general billing and reimbursement information for outpatient facility services, as well as information specific to each of the four categories of service defined within the CMS hospital outpatient prospective payment system (OPPS):

- Outpatient surgeries
- Treatment room visits
- Add-on services (including certain drugs, supplies, and medical equipment)
- Stand-alone services (including therapy, renal dialysis, laboratory, radiology, and chemotherapy)

For additional information about emergency room services, see the [Emergency Services](#) module.

For information about birthing centers, see the [Obstetrical and Gynecological Services](#) module.

Note: The IHCP developed the coverage policies, reimbursement policies, and billing requirements of the outpatient prospective payment system. The IHCP does not intend for these policies and requirements to mirror the policies and procedures of the Medicare program.

¹ End-stage renal disease (ESRD) clinics and birthing centers bill as outpatient facilities. All other IHCP-enrolled clinics bill as professional or dental providers. For information about comprehensive outpatient rehabilitation facility (CORF) billing, see the [Therapy Services](#) module.

Reimbursement for Outpatient Facility Services

Outpatient facility pricing calculates a flat rate for emergency department treatment rooms and nonemergency department treatment rooms. Additionally, certain outpatient facility services are reimbursed separately as add-ons or as stand-alone services. For a list of all revenue codes reimbursed by the IHCP, as well as outpatient payment information for relevant codes, see *Revenue Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Rates for outpatient procedure codes and ASC pricing indicators assigned to procedure codes are listed in the Outpatient Fee Schedule, accessible from the *IHCP Fee Schedules* page at in.gov/medicaid/providers. The ASC rates and effective dates associated with ASC pricing indicators are listed in the [ASC Code/Rate table](#), also accessible from the *IHCP Fee Schedules* page.

Providers are reimbursed the lesser of their submitted charges or the Medicaid-allowed amount for applicable outpatient facility services, except when the Hospital Assessment Fee (HAF) hospital adjustment factor has been applied. See the [Hospital Assessment Fee](#) module for more information.

Rate Reduction

For dates of service from January 1, 2014, through June 30, 2021, the IHCP implemented a 3% reduction in reimbursement for inpatient and outpatient hospital services. The allowed amount for each detail line of outpatient and outpatient crossover claims is calculated using the current reimbursement methodology. Third party liability (TPL) is subtracted from the total allowed amount of the claim.

The rate reduction is not applicable for state-operated psychiatric hospitals or for disproportionate share hospitals (DSHs).

For HAF-participating hospitals, the 3% rate reduction applies only to clinical laboratory services. For all other services performed at a HAF-participating hospital, the allowed amount for each detail line of outpatient and outpatient crossover claims is calculated using the current reimbursement methodology multiplied by the outpatient hospital adjustment factor. The hospital adjustment factors and corresponding dates are listed in the [Hospital Assessment Fee](#) module.

Coverage and Billing for Outpatient Facility Services

IHCP fee-for-service outpatient claims must be submitted on an institutional claim (*UB-04* claim form, IHCP Provider Healthcare Portal institutional claim, or 837I electronic transaction). See the [Claim Submission and Processing](#) module for general billing instructions.

If submitting the claim on a *UB-04* claim form, providers must mail the completed forms to DXC Technology at the following address for processing:

DXC Outpatient Claims
P.O. Box 7271
Indianapolis, IN 46207-7271

Outpatient Service within 3 Days before an Inpatient Stay

Outpatient services rendered within 3 days preceding an inpatient admission to the same facility for the same or related diagnosis are considered part of the corresponding inpatient admission.

Note: "Same or related diagnosis" refers to the primary diagnosis code and is based on the first three digits of the ICD code.

In this situation, the outpatient services will not be reimbursed separately from the inpatient claim:

- If an outpatient claim is submitted for the services and is paid before the inpatient claim is submitted, the inpatient claim will be denied with explanation of benefits (EOB) 6515 – *Inpatient services performed three days after outpatient DOS [date of service]*. To resolve this denial, providers should void the outpatient claim in history, incorporate the outpatient services into the inpatient claim, and resubmit the corrected inpatient claim.
- If an outpatient claim is submitted after the inpatient claim has been paid, the outpatient claim will be denied with EOB6516 – *Outpatient services performed three days prior to inpatient admission*. This EOB indicates that the inpatient claim may be adjusted to reflect the outpatient services provided to the patient.

Inpatient claims billed with outpatient charges for services rendered at the same facility within 3 days before an admission should reflect the *from* and *through* dates of the inpatient stay, not the date the outpatient services were rendered. However, for all services on the inpatient claim, including services rendered as outpatient procedures prior to admission, providers must enter the date that the procedure was actually performed in fields 74 and 74a–e of the *UB-04* claim form (or in the corresponding fields of the electronic claim).

Providers are required to submit an inpatient claim only when both the outpatient and inpatient services occur at their facility. This policy is not applicable when the outpatient and inpatient services are provided by different facilities.

Outpatient services provided within 3 days preceding a **less-than-24-hour** inpatient stay are billed as an outpatient service.

Inpatient Stays Less than 24 Hours

Providers should bill inpatient stays that are less than 24 hours in duration as an outpatient service. See the [Inpatient Hospital Services](#) module for exceptions to this rule.

Observation Billing

Observation services (including the use of a bed and periodic monitoring by a hospital's nursing staff) are reimbursable when they are furnished by a hospital on the hospital's premises and they are reasonable and necessary to evaluate the patient's condition or determine the need for possible admission to the hospital as an inpatient.

Providers can retain members for more than one 23-hour observation period when the member has not met criteria for admission but the treating physician believes that allowing the member to leave the facility would likely put the member at serious risk. This observation period can last *not more than 3 days or 72 hours and is billed as an outpatient claim*.

Observation services rendered as outpatient procedures but occurring within 72 hours of an admission must be billed as an inpatient claim, as described in the [Outpatient Service within 3 Days before an Inpatient Stay](#) section.

Outpatient Surgeries

The IHCP reimburses an all-inclusive ASC rate for outpatient surgeries provided in a hospital or an ASC. This rate includes all services related to the surgery, with the exception of certain durable medical equipment (DME) implanted during the surgery. For a list of items that are separately reimbursable for the outpatient surgery; see the *Implantable DME Separately Reimbursable in the Outpatient Setting* table in *Surgical Services Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. The facility provider should submit claims for these items, and only these items, on the professional claim (CMS-1500 claim form or electronic equivalent) for separate reimbursement in addition to the institutional claim.

See the [Surgical Services](#) module for more information about outpatient surgery billing and reimbursement.

Note: The IHCP does not cover surgical or other invasive procedures to treat particular medical conditions when the practitioner performs the surgery or invasive procedure erroneously. The IHCP also does not cover services related to these noncovered procedures. All services provided in the operating room when an error occurs, and all related services provided during the same hospitalization in which the error occurred, are not covered. See the Provider Preventable Conditions section in the [Surgical Services](#) module for more information.

Treatment Room Visits

For purposes of the IHCP's outpatient prospective payment system, *treatment rooms* include emergency rooms, clinics, cast rooms, labor and delivery rooms, and observation hours. The IHCP allows multiple treatment room visits **of differing types** on the same day. Overutilization is subject to postpayment review.

The IHCP reimburses *emergency room services* for the treatment of ill and injured patients who require immediate, unscheduled medical or surgical care. The IHCP reimburses *clinic services* for diagnostic, preventative, curative, and rehabilitative services provided to ambulatory patients.

The *Revenue Codes and Outpatient Payment Methodologies* table indicates which revenue codes are treatment room revenue codes. See *Revenue Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Note: When surgeries are performed in a treatment room, the appropriate surgical Current Procedural Terminology (CPT®²) code should accompany the treatment room revenue code, and reimbursement is based on the ASC methodology. (See the [Surgical Services](#) module for details.) Facilities should otherwise not use a surgical CPT code in addition to the treatment room revenue code.

Providers may bill stand-alone services in conjunction with treatment room services. Stand-alone services include services such as therapies, dialysis, radiology, and laboratory. See the [Stand-Alone Services](#) section of this document for details.

The IHCP allows certain add-on services, described in the [Add-On Services](#) section of this document, if they are billed in conjunction with a treatment room visit. All other add-on services are denied if billed in conjunction with a treatment room service.

² CPT copyright 2019 American Medical Association. All rights reserved. CPT is a registered trademark of the American Medical Association.

Under the fee-for-service reimbursement methodology, treatment room services are reimbursed at a flat rate that includes most drugs, injections, and supplies. The following policies and billing guidelines apply:

- **Administration of injections** – Reimbursement for the administration of therapeutic or diagnostic injections, including vaccines, is incorporated in the established rate for the treatment room in which the injection was administered (such as 450 – *Emergency room* or 510 – *Clinic*). Therefore:
 - When other services besides the injection are provided in the treatment room setting, administration of the injection is not separately reimbursable.
 - If a patient receives **only** an injection service in the treatment room, and no other service is provided, the provider is instructed to bill **only** revenue code 260 – *IV therapy – General* along with the procedure code for the administration of the injection. No treatment room revenue code should be billed.
- **Infusions** – The IHCP considers infusions to be a stand-alone service. Therefore:
 - When infusions are performed in conjunction with other services in a treatment room, providers may bill revenue code 260 along with the procedure code for the administration of the infusion, on a separate detail line from the treatment room revenue code.
 - When performing **only** an infusion, providers may bill **only** revenue code 260 along with the procedure code for the administration of the infusion. No treatment room revenue code should be billed.
- **Orthotic and prosthetic devices** – The IHCP allows separate reimbursement for certain designated orthotic and prosthetic devices when provided in conjunction with treatment room services and billed with revenue code 274 – *Orthotic/prosthetic devices*.
- **Drugs** – The IHCP allows separate reimbursement for certain designated drugs when provided in conjunction with treatment room services and billed with revenue code 636 – *Drugs Requiring Detailed Coding*.

For procedure codes that can billed with revenue codes 260, 274, and 636 for separate reimbursement in addition to the treatment room rate, see *Revenue Codes Linked to Specific Procedure Codes*, accessible from the [Code Sets](#) page at in.gov/medicaid/providers. For special procedure code linkages for revenue code 724 – *Birth center*, see the [Obstetrical and Gynecological Services](#) module.

Note: Although revenue code 451 (Emergency room – Emergency Medical Treatment and Labor Act (EMTALA) emergency medical screening services) is sometimes classified as a treatment room code, it is more accurately described as a “triage” code, used for screening costs when a patient presents in the ER for a nonemergency condition. When revenue code 451 is billed, all other lines on the claim for that date of service will be denied.

Add-On Services

The IHCP reimburses add-on services at a flat, statewide rate when billed with a stand-alone procedure. In addition, some add-on services are also separately reimbursable if billed in conjunction with a treatment room revenue code. Add-on services are not separately reimbursable if provided on the same day as an outpatient surgery. Each add-on revenue code is restricted to one unit per provider per date of service.

The *Revenue Codes and Outpatient Payment Methodologies* table indicates which revenue codes are used for add-on services and indicates whether the add-on revenue code is separately reimbursable from a treatment room code. See *Revenue Codes* accessible from the [Code Sets](#) page at in.gov/medicaid/providers.

Stand-Alone Services

Stand-alone services include therapies, diagnostic testing, dialysis, laboratory services, and radiology procedures performed in an outpatient setting. Providers can bill stand-alone services separately or in conjunction with treatment room services. Stand-alone services are not separately reimbursable with outpatient surgeries if provided on the same day as the surgery. Certain stand-alone revenue codes are restricted to one unit per provider per date of service.

The IHCP reimburses stand-alone services such as dialysis and physical, occupational, and speech therapies at an established flat statewide rate. Laboratory and radiology services are reimbursed at the lower of the charge submitted on the claim or the Fee Schedule amount.

The *Revenue Codes and Outpatient Payment Methodologies* table indicates which revenue codes are used for stand-alone services and whether the stand-alone revenue code is restricted to one unit per date of service. See *Revenue Codes* on the [Code Sets](#) page at in.gov/medicaid/providers.

Stand-Alone Chemotherapy and Radiation Services

Providers should bill all outpatient facility chemotherapy and radiation treatment services on the institutional claim (*UB-04* claim form or electronic equivalent).

Chemotherapy services consist of five components that are separately reimbursable when billed as follows:

- **Administration of chemotherapy agent** – Bill using revenue codes 331, 332, or 335, along with the appropriate chemotherapy CPT codes (96401 through 96549).
- **Chemotherapy agent** – Bill using revenue code 636 – *Drugs requiring detailed coding*, along with the appropriate Healthcare Common Procedure Coding System (HCPCS) code. Preparation of chemotherapy agents is included in the service for administration of the agent.
- **IV solution** – Bill using revenue code 258.
- **IV equipment** – Bill using revenue code 261. No reimbursement will be made for other revenue codes associated with supplies.
- **Treatment room services** – Bill using revenue codes 45X, 48X, 51X, 52X, or 76X.

Radiation treatment services consist of two components that are separately reimbursable when billed as follows:

- **Administration of radiation treatment** – Bill using revenue codes 330, 333, or 339, along with the appropriate radiation treatment CPT code (77261 through 77799).
- **Treatment room services** – Bill using revenue codes 45X, 48X, 51X, 52X, or 76X.

Note: When chemotherapy and radiation treatment services are rendered on the same day, bill all applicable components to the IHCP.